

# MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

317 547 3008  
FILED OCT 26 1962

VS 300  
Rev. 4/59

1 4005  
2 4019  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Richmond Heights</u>		c. CITY OR TOWN <u>Creve Coeur</u>	
Length of stay in 1b <u>14 hrs.</u>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) <u>ST. MARY'S Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>1231 Ross Ave.,</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Delores E. Newcomb</u>		4. DATE OF DEATH <u>10/18/62</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/12/1926</u>
9. AGE (last birthday) <u>36</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (City and state or country) <u>St. Louis Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James Frazee</u>		13b. MOTHER'S MAIDEN NAME <u>Olivia Mertz</u>	
14. NAME OF HUSBAND OR WIFE <u>Orville Newcomb</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Orville Newcomb, Creve Coeur, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLISM</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>AURICULAR FIBRILLATION</u>		<u>6 HOURS</u>	
DUE TO (c) <u>Rheumatic Heart Disease</u>		<u>25 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20f. CITY, TOWN, OR LOCATION		COUNTY	
20g. STATE		20h. DATE OF DEATH	
21. I attended the deceased from <u>10/58</u> to <u>10/18/62</u> and last saw her alive on <u>10/18/62</u>		Death occurred at <u>2:09 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Marten G. Austin MD</u>		22b. ADDRESS <u>11745 OLIVE St. Road</u>	
22c. DATE SIGNED <u>10/18/62</u>		22d. LOCATION (City, town, or county) (State) <u>Pa. &amp; St. Charles Rk. Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/20/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Gardens</u>	
23d. FUNERAL DIRECTOR <u>Schrader Funeral Home, Ballwin, Mo.</u>		23e. DATE RECD. BY LOCAL REG. <u>10-18-62</u>	
23f. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>		23g. DATE <u>10/18/62</u>	

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Richard Bopp*

Licensed Embalmer No.

*4584*

P. O. Address

*Ballwin, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.